State Approaches to Rate Setting & Payments

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Topics

- Themes across states
- Examples…you are not alone

Themes

- States are shedding "negotiated" payment rate approaches in favor of using standardized rate setting methods
- Standardization:
  - Formal rate models keyed to direct support staff hours
  - Tying rates on "difficulty of care" factors
  - Standardized wages
  - Standardized benefit amounts/allowances
  - Uniform allowances for overhead costs

State Policy Objectives

- Uniform payments across all providers
- Design payments to reflect differences in individual support needs rather than provider-to-provider variations in costs
- Standardization is key to portability and promoting consumer free choice of provider
- Ensure federal compliance

What's going on …

- States are in different places –
  - Some made changeover to fee-for-service long ago
  - Others are just now starting the transition
- Many states are designing more sophisticated rate setting methods
- Redesign often includes acquiring provider cost data and linking to consumer assessment results

Design Standards

- Rates should be reflective of actual provider costs
- Rates should take into account factors that affect costs (e.g., travel time, etc.)
- Rates are built with direct service staffing at the core
- Benchmark rates to external data (e.g., BLS wage survey, etc.)

Example: Arizona

- Revised payments five years ago
- Developed models for all community services
- All models are based on the amount of direct service staffing
- Acquired provider cost data
- Included "productivity" factors to take into account staff time spent off-line from individuals

Arizona: Continued

- Built in urban/rural and density factors
- Used “benchmark” rate concept
- Progressively over the years, state boosted rates until it reached benchmark
- Provision for rebasing costs every five years
- Very precise system

Indiana

- Individual resource levels were “all over the map”, inequitable and mainly a reflection of when someone entered the system
- Resources not accurately tied to individual need nor actual costs of services

Indiana

- Oasis: *The **O**bjective **A**ssessment **S**ystem for **I**ndividual **S**upports*
- Create a uniform funding model
  - Based on an objective assessment
  - Fair and equitable
  - Driven by person-centered planning
  - With measurable outcomes

Indiana

CMS pressures:

- Provider be reimbursed ONLY for actual services delivered
- Rates be “discreet and transparent”
- Rate treat *providers* in a fair and equitable way
- Indiana must develop a standardized fee schedule to implement OASIS

Indiana

- Steps:
  - Cost study and market analysis
    - Provider cost data obtained from the provider costs reports completed by each agency
  - Rate development
    - Rates developed using provider cost data and market analysis data
  - Rate shadowing:
    - Providers compare current level of reimbursement with the projected reimbursement
  - Rate testing
    - Rate adjustments and revisions made as needed
  - Implementation

Indiana

- Cost Study-29 services
  1. COST CENTER 2 – Administrative Staff Compensation Expenses
  2. COST CENTER 3 – Program-Related and Clinical Staff Compensation Expenses
  3. COST CENTER 1 – Direct Care Staff Compensation Expenses
  4. COST CENTER 4 - Supplies, Materials, Transportation, and Equipment Expenses
  5. COST CENTER 5 – Facility-Based Expenses
  6. Factors for agency size and geography

- Plus an itemized expenditure worksheet detailing everything else spent

Indiana

- Have completed the first round of analysis of costs
- Have set rates for shadowing
- Testing proposed "shadow" rates and revenues against actual invoices (at current rates)
- Final rates will be based on what is learned

Indiana

- Requires adjustments based on actual data
- Takes into account the financial impact on providers
- Makes adjustments based on agency size and geography
- Getting to final rates will take time—2 year process

Montana: This is the don't worry too, too much slide…

- Similar to Indiana (same contractor…)
- Both a resource allocation process and a rate process
- Interesting evaluation results:
  - Service levels were maintained or increased and service needs met for 37 out of 40 consumers or 94%.
    1. Service levels were maintained for 75% (30 of 40)
    2. Service levels increased for 18% (7 of 40)
    3. Service levels were insufficient for 7% (3 of 40)

Montana

- The majority of quality assurance items measured showed the same or slightly improved levels.
- *ALL providers were able to maintain or increase direct care wages*.
- Six out of seven providers were able to invoice for the total number of direct care hours and met their revenue projections

Other States

- Other states that have engaged in redesign include:
  - Ohio
  - Florida
  - South Dakota

So….

- Redesign and rate restructuring do not necessarily have mean disruption
- Rate restructuring can surface and correct long-standing inequities
  - For provider
  - For consumers
- Rate restructuring brings states into compliance with Medicaid requirements including freedom of choice and portability and…
- Preserves the funding stream